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Office of Administrative Law Judges
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Issue Date: 23 January 2006

Case No. 2003-BLA-5172

In the Matter of:
DEBRA MAYNARD STANLEY,
Claimant,

v.

NALR COAL CORP.,
Employer,
and,
KENTUCKY EMPLOYERS MUTUAL INSURANCE,
Carrier,

and,

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Respondent.

APPEARANCES:
Susie Davis, Lay Representative
On behalf of Claimant

Paul E. Jones, Esq.
On behalf of Respondent

BEFORE: THOMAS F. PHALEN, JR.
Administrative Law Judge

DECISION AND ORDER – DENIAL OF BENEFITS

This is a decision and order arising out of a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1977, 30 U.S.C. §§ 901-962, ("the Act") and the regulations thereunder, located in Title 20 of the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title.[1]

[1] The Department of Labor amended the regulations implementing the Federal Coal Mine Health and Safety Act of 1969, as amended. These regulations became effective on January 19, 2001, and are found at 65 Fed. Reg. 80, 045-80,107 (2000)(to be codified at 20 C.F.R. Parts 718, 722, 725 and 726). On August 9, 2001, the United States District Court for the District of Columbia issued a Memorandum and Order upholding the validity of the new regulations. All citations to the regulations, unless otherwise noted, refer to the amended regulations.

On November 25, 2005, this case was received at the Office of Administrative Law Judges from the Director, Office of Workers' Compensation Programs, for a hearing. (DX 30).[2] A formal hearing on this matter was conducted on February 18, 2004, in Pikeville, Kentucky by the undersigned Administrative Law Judge. All parties were afforded the opportunity to call and to examine and cross examine witnesses, and to present evidence, as provided in the Act and the above referenced regulations. At the hearing, however, the parties agreed to a decision on the record. The parties were granted 30 days to submit briefs, and upon expiration of that period, the record was closed. (Tr. 10).

The record in this claim includes Administrative Law Judge Exhibit 1, Director Exhibits 1-30, and Claimant's and Employer's evidence summary forms.[3] As there were no objections to these submissions, they are admitted into the record.

ISSUES[4]

The issues in this case are:

1. Whether the Miner had pneumoconiosis as defined by the Act;

2. Whether the Miner's pneumoconiosis arose out of coal mine employment;

3. Whether the Miner's death was due to pneumoconiosis; and

4. Whether Claimant is an eligible survivor of a miner.

(DX 30; Tr. 9-10).

Based upon a thorough analysis of the entire record in this case, with due consideration accorded to the arguments of the parties, applicable statutory provisions, regulations, and relevant case law, I hereby make the following:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

[2] In this Decision, "DX" refers to the Director's Exhibits, "EX" refers to the Employer's Exhibits, "CX" refers to the Claimant's Exhibits, and "Tr." refers to the official transcript of this proceeding

[3] These forms will be designated CX 1 and EX 1, respectively.

[4] At the hearing, Employer withdrew as uncontested the following issues: whether the claim was timely filed; whether the named employer is the responsible operator; and whether the miner's most recent period of cumulative employment of not less than one year was with the named responsible operator. (Tr. 9). The parties also stipulated to 15 years of coal mine employment. (Tr. 9). Total disability was marked on the designation form, but is not an issue in this survivor's claim. §718.205(c). Finally, Employer listed other issues that will not be decided by the undersigned; however, they are preserved for appeal. (Item 18(B) DX 32).

Procedural History

James Darrell Maynard, ("Miner"), died on January 25, 2001. (DX 1, 5). Debra Rose Maynard, ("Claimant") filed a claim for survivor benefits on March 9, 2001. (DX 1). On September 23, 2002, the District Director, OWCP issued a proposed decision and order awarding benefits. (DX 23). Employer requested a formal hearing. (DX 24). On November 13, 2002, the Director issued an amended award of benefits, concluding that due to Claimant's remarriage in October 2001, her last month of eligibility for survivor benefits was September 2001. (DX 27). Again, Employer requested a formal hearing. (DX 29). This matter was transferred to the Office of the Administrative Law Judges. (DX 30).

Eligible Survivor

Miner married Claimant on December 7, 1973, and they remained married for 28 years, until Miner's death. (DX 1, 4). Miner and Claimant did not have any dependent children. (DX 1). Claimant married Charles Stanley on October 19, 2001. (DX 13). I find that Claimant was an eligible surviving spouse of Miner at the time of his death, but due to her remarriage in October 2001, this eligibility ended in September 2001. §725.213(b).

Length of Coal Mine Employment

The Social Security Earnings records and the other evidence of record establishes, and I find, that Miner was a coal miner within the meaning of § 402(d) of the Act and § 725.202 of the regulations. The parties stipulated that Miner engaged in at least 15 years of coal mine employment. (Tr. 9). Since the parties' stipulation is supported by the record, (DX 2-3). I find that Miner engaged in at least 15 years of coal mine employment.

Miner's last employment was in the Commonwealth of Kentucky (DX 9); therefore, the law of the Sixth Circuit is controlling. [5]

Responsible Operator

Liability under the Act is assessed against the most recent operator that meets the requirements of §§ 725.494 and 725.495. The District Director identified NALR Coal Corp. as the most recent operator to employ Miner for at least one year. (DX 9, 23). NALR Coal Corp. does not contest this issue. (Tr. 9). After review of the record, I find that NALR Coal Corp. is properly designated as the responsible operator in this case.

MEDICAL EVIDENCE

Section 718.101(b) requires any clinical test or examination to be in substantial compliance with the applicable standard in order to constitute evidence of the fact for which it is proffered. *See* §§ 718.102 - 718.107. The claimant and responsible operator are entitled to

[5] Appellate jurisdiction with a federal circuit court of appeals lies in the circuit where the miner last engaged in coal mine employment, regardless of the location of the responsible operator. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200 (1989)(en banc).

submit, in support of their affirmative cases, no more than two chest x-ray interpretations, the results of no more than two pulmonary function tests, the results of no more than two blood gas studies, no more than one report of each biopsy, and no more than two medical reports. §§ 725.414(a)(2)(i) and (3)(i). Any chest x-ray interpretations, pulmonary function studies, blood gas studies, biopsy report, and physician's opinions that appear in a medical report must each be admissible under § 725.414(a)(2)(i) and (3)(i) or § 725.414(a)(4). §§ 725.414(a)(2)(i) and (3)(i). Each party shall also be entitled to submit, in rebuttal of the case presented by the opposing party, no more than one physician's interpretation of each chest x-ray, pulmonary function test, arterial blood gas study, or biopsy submitted, as appropriate, under paragraphs (a)(2)(i), (a)(3)(i), or (a)(3)(iii). §§ 725.414(a)(2)(ii), (a)(3)(ii), and (a)(3)(iii). Notwithstanding the limitations of §§ 725.414(a)(2) or (a)(3), any record of a miner's hospitalization for a respiratory or pulmonary or related disease, or medical treatment for a respiratory or pulmonary or related disease, may be received into evidence. § 725.414(a)(4). The results of the complete pulmonary examination shall not be counted as evidence submitted by the miner under § 725.414. § 725.406(b).

Claimant completed a Black Lung Benefits Act Evidence Summary Form. (CX 1). Claimant designated Dr. Musgrave's January 25, 2001 death certificate. As this reports complies with the quality standards of §§ 718.102-107 and the limitations of § 725.414(a)(3), I admit it into evidence. Claimant also designated Dr. Phillips' January 4, 2000 biopsy report. While this report is admissible, it has not been included in the record. Therefore, the January 2000 biopsy report will not be considered in the instant adjudication.

Employer completed a Black Lung Benefits Act Evidence Summary Form. (EX 1). Employer designated Drs. Fino and Caffrey's medical reports and supporting depositions. Employer also designated the hospital records from the Pikeville United Methodist Hospital. Employer's evidence complies with the requisite quality standards of §§ 718.102-107 and the limitations of § 725-414 (a)(3). Therefore, I admit the evidence Employer designated in its summary form.

The record also includes treatment records by Dr. Mettu, which were not designated by either party. (DX 6). While most of the relevant reports contained in these records are duplicates of those found in the Pikeville Hospital treatment records, there are a couple of reports not found within this history. Therefore, for the purpose of completeness of Miner's treatment history, I find good cause to admit Dr. Mettu's treatment records into evidence. In addition, the record includes a letter from Dr. Musgrave. (DX 8). Even though this report was not designated by either party, I find that based on his status as Miner's treating physician, there is good cause to consider this report in the adjudication of the instant claim.

PULMONARY FUNCTION TESTS

Exhibit/ Date	**Co-op./ Undst./ Tracings**	**Age/ Height**	**FEV_1**	**FVC**	**MVV**	**FEV_1/ FVC**	**Qualifying Results**
DX 7 3/22/00	Good/ Good/ Yes	46 66"	**1.47**	2.84	**72**	**52**	**Yes**

ARTERIAL BLOOD GAS STUDIES

Exhibit	Date	pCO_2	pO_2	Qualifying
DX 7	12/27/99	42.2	84.1	No
DX 7	08/18/00	39.6	79.6	No
DX 7	08/20/00	33	78.5	No
DX 7	08/21/00	24.8	69.1	Yes
DX 7	08/23/00	40.1	127.4	No
DX 7	09/26/00	40	106.5	No
DX 7	10/05/00	36.5	75.7	No
DX 7	12/04/00	45.6	89.8	No
DX 7	01/03/01	44.8	84.4	No
DX 7	01/04/01	50.5	85.2	Yes
DX 7	01/11/01	48.4	74.5	No
DX 7	01/17/01	40.7	79.3	No
DX 7	01/22/01	42.3	77.3	No
DX 7	01/24/01	46.9	46.3	Yes

Hospital and Treatment Records[6]

The record contains treatment notes from Pikeville Methodist Hospital of Kentucky and treatment records from Dr. Mettu (DX 6-7). These records span from May 1977 through February 2001, and the entries pertinent to this claim for benefits are reproduced below in chronological order.[7]

May 27, 1977 – X-ray report by Dr. Combs: There is minimal infiltrate posteriorly at the right base. Remaining lung parenchyma is clear. Impression: minimal infiltrate at the right base suggestive of pneumonia.

May 28, 1977 – Examination report by Dr. Cox: Patient presents with shortness of breath, wheezing, cough, and fever. Chest x-ray was clear. He was advised to decrease his cigarette consumption. Lung examination revealed scattered coarse rhonchi throughout all lung fields. Impression: bronchitis or pneumonia.

May 31, 1977 – X-ray report by Dr. Combs: The lung fields are clear. Impression: normal chest.

[6] This treatment record includes several x-ray interpretations. There is no evidence in the record as to the x-ray reading credentials of the providing physicians. Also, several of these interpretations were related to the treatment of Miner's condition, and not taken for the purpose of determining the existence or extent of pneumoconiosis. Finally, there is no record of the film quality for any of these x-rays. As a result, the treatment x-ray results are not in compliance with the quality standards of §718.102 and Appendix A to Part 718, and will not be considered under § 718.202(a)(1).

[7] All entries, unless otherwise noted, can be found in Director's Exhibit 7.

July 5, 1977 – Examination report by Dr. Cox: Patient presents with shortness of breath and fever. Examination showed scattered, loose rhonchi throughout all lung fields and inflamed pharynx on admission. His chest cleared after a couple of days in the hospital. Impression: acute bronchitis.

October 29, 1980 – X-ray report by Dr. Kim: the lung fields are clear. Impression: negative chest.

October 31, 1980 – X-ray report by Dr. Kim: The lung fields are clear. Impression: normal chest.

November 3, 1980 – Lung scan report by Dr. Halbert: Ventilation and perfusion scans of the lungs reveal no abnormality.

November 17, 1980 – Examination report by Dr. Malik: Patient presented complaining of pain in the left chest. Physical examination revealed clear lungs. EKG showed sinus rhythm slight nondiagnostic STT changes. X-rays were normal. Lung scan was negative. Diagnosis: chest and epigastric pain of undetermined etiology.

December 26, 1999 – X-ray report by Dr. Halbert: Acute infiltrates are seen but the pleura and diaphragm are unremarkable. Compared to the 8/19/97 study, there is no significant change. Impression: no evidence of active disease.

December 27, 1999 – Emergency room report by Dr. Irwin: History of multiple myeloma and has undergone two stem cell transplants. X-ray reveals some very, very small nodularities consistent with silicosis. Impression. Multiple myeloma.

December 27, 1999 – Examination report by Dr. Musgrave: History of IgG multiple myeloma status post peripheral stem cell transplant and an unknown lung disease thought to he occupational in nature. Patient presents with slight shortness of breath. He chewed tobacco for about six years. Lung examination is unremarkable. Impression: IgG multiple myeloma, weakness with questionable etiology that may be related to his underlying lung disease, and hypoxia.

December 27, 1999 – ABG study by Dr. Musgrave (see chart above).

January 1, 2000 – X-ray report by Dr. Kendrall: Compared to 12/27/99, there is no evidence of active disease.

January 2, 2000 – Admission report by Dr. Puram: History of unsuccessful treatment for IgG multiple myeloma, fibronocular lung disease, and lung mass removal in 1996. Patient chewed tobacco for about 6 years. Lung examination showed diminished breath sounds but no rhonchi. Impression: acute bronchitis and IgG multiple myeloma.

January 7, 2000 – Discharge report by Dr. Musgrave: History of IgG multiple myeloma and fibronodular lung disease. Lung examination revealed diminished breath sounds. He was

admitted, placed on fluids and medication including nebulizer treatments. Diagnosis: multiple myeloma.

March 22, 2000 – PFT study by Dr. Mettu: Severe obstructive airway disease with decreased MVV; FVC is decreased; lung volumes are consistent with obstructive airway disease; DLCO is moderately severely decreased. (See chart above).

March 23, 2000 – X-ray report by Dr. West: Cardiopulmonary structures are within normal limits. Impression: no definite active pathology.

May 19, 2000 – X-ray report by Dr. Kendrall: Comparison to 3/23/00 reveals clear lung fields. Impression: normal chest.

May 20, 2000 – Examination report by Dr. Musgrave: History of IgG multiple myeloma and silicosis. He does not smoke. Lung examination revealed diminished breath sounds. Impression: multiple myeloma and silicosis.

May 25, 2000 – Discharge summary by Dr. Musgrave: Physical examination revealed diminished breath sounds. Diagnosis: multiple myeloma and silicosis.

July 4, 2000 – X-ray report by Dr. West: Lung fields are clear. Impression: normal chest.

July 4, 2000 – Examination report by Nurse Hess: Respirations were shallow, cough was non-productive, and breath sounds were decreased.

July 4, 2000 – Emergency room report by Dr. Iluyomade: Patient with a history of IgG multiple myeloma, status post stem cell transplantation times 2, silicosis, and COPD presents with a fever, nausea, and cough. He does not smoke, but used to chew tobacco. Lung examination revealed inspiratory fine crackles on the left upper lung fields, but no wheezes or rales, and chest wall movement is normal. Chest x-ray shows some hiliar densities, other wise no specific infiltrates. Final diagnosis: possible pneumonia.

July 5, 2000 – Admission report by Dr. Puram: Patient with a history of IgG multiple myeloma and received 2 cycles of Aredia following two stem cell transplants with a relapse of disease. He does not smoke. Patient uses nebulizers and presented with shortness of breath, and increasing shoulder and back pain. Lung examination revealed diminished breath sounds with crepitant rales on both sides. Assessment: acute bronchitis and refractory multiple myeloma.

July 5, 2000 – Pain management consultation by Dr. Briggs: History of multiple myeloma and two failed stem cell transplants and COPD. Chemotherapy was discontinued due to intolerable side effects. He was admitted today because of fever and chills and was thought to have acute bronchitis. He does not smoke. Patient presented with increased shortness of breath, increased pain, and nausea. Lungs were clear to auscultation. Assessment: Multiple myeloma.

July 10, 2000 – X-ray report by Dr. Kendrall: Comparison to 7/4/00 reveals no acute infiltrates and the pleura and diaphragm are unremarkable. Impression: no evidence of active disease.

July 21, 2000 – Discharge summary by Dr. Musgrave: Patient has a history of IgG myeloma and has had two bone marrow transplants with relapse. Physical examination reveals diminished breath sounds with some rales on both sides. He was admitted and given IV fluids and placed on IC Rocephin. He was discharged on 7/12/00.

August 3, 2000 – Pain clinic note by Dr. Briggs: Patient with a history of IgG multiple myeloma post failed stem cell transplants. Lungs are clear to auscultation. Assessment: multiple myeloma.

August 8, 2000 – Examination report by Nurse Blair: Lung examination reveals normal respiration, no cough, and clear breath sounds. Patient uses O2.

August 9, 2000 – Examination report by Dr. Briggs: Patient with a history of IgG multiple myeloma post failed stem cell transplant and chemotherapeutic control and COPD presented with pain. He does not smoke. Lungs are clear to auscultation. Impression: intractable back pain secondary to multiple myeloma.

August 11, 2000 – Consultation report by Dr. Musgrave: Patient has a history of IgG multiple myeloma post failed stem cell transplant. He does not smoke. Patient was admitted for pain control. Lungs are clear to auscultation. Assessment: myeloma with refractory pain.

August 16, 2000 – Examination report by Dr. Musgrave: Patient has history of multiple myeloma status post two bone marrow transplants, occupational lung disease with silicosis and had problems with frequent respiratory infections. He does not smoke. Patient presents with shortness of breath, repetitive, dry cough, and low grade temperature. Lung examination reviews diminished breath sounds throughout the lung fields. Impression: multiple myeloma and chronic lung disease.

August 16, 2000 – Consultation report by Dr. Mettu: Patient with a history of silicosis and COPD presents with shortness of breath and cough. He does not smoke. Lung examination reveals no bruits. The X-ray shows that the lung fields are clear. Impression: shortness of breath, COPD, history of silicosis, and multiple myeloma.

August 17, 2000 – X-ray report by Dr. Kendall: There is mild bibasilar atelectasis but no evidence of pleural effusion.

August 18, 2000 – ABG report by Dr. Musgrave (see chart above).

August 20, 2000 – ABG report by Dr. Musgrave (see chart above).

August 21, 2000 – ABG report by Dr. Musgrave (see chart above).

August 21, 2000 – X-ray report by Dr. Poulos: Comparison to the 8/17/00 study reveals that the lungs are slightly better expanded with decrease in the atelectatic changes seen in both lung bases. At this time, no areas of volume loss, infiltration, or pleural disease is identified.

Impression: resolution of the atelectatic changes seen in both lung bases, no active disease is noted.

August 22, 2000 – Perfusion and ventilation lung scan by Dr. Poulos: The exam reveals homogeneous perfusion noted throughout both lung fields. The ventilation study shows good wash-in of tracer but retention on the wash-out phase. The changes are compatible with a component of COPD. There is a low probability for pulmonary embolis.

August 23, 2000 – ABG report by Dr. Musgrave (see chart above).

August 25, 2000 – X-ray report by Dr. Poulos: The lung fields are clear. Impression: normal chest.

August 29, 2000 – X-ray report by Dr. Poulos: The lung fields are clear and the chest is normal.

September 8, 2000 – Discharge summary by Dr. Musgrave: Patient has history of multiple myeloma status post two bone marrow transplants, occupational lung disease with silicosis and had problems with frequent respiratory infections. He presents with shortness of breath, repetitive, dry cough, and low grade temperature. Lung examination reveals diminished breath sounds. Patient was admitted and placed on nebulizer treatments. He was discharged on September 5, 2000. Impression: myeloma causing severe pain and chronic lung disease with exacerbation.

September 23, 2000 – Examination report by Dr. Musgrave: Patient has a history of myeloma status post two bone marrow transplants and silicosis. He presented with a productive cough, increased chest congestion, shortness of breath, and chills. He does not smoke. Physical examination reveals diminished breath sounds with rhonchi throughout his lung fields especially prominent in the posterior bases. Impression: respiratory infection, silicosis, and myeloma.

September 23, 2000 – X-ray report by Dr. Kendall: Compared to 8/29/00. There is mild atelectasis within the right lung base. Lungs are otherwise clear. Impression: mild right basilar atelectasis.

September 24, 2000 – Consultation report by Dr. Mettu: Patient has a history of multiple myeloma, COPD, silicosis, and prior pneumonia. He does not smoke and is a retired coal miner. He was admitted with shortness of breath, cough, and chest congestion. He also has symptoms of sleep apnea. The lungs were clear on examination. Impression: excessive daytime sleepiness, COPD, multiple myeloma, and pneumonia in the right lower lobe.

September 25, 2000 – X-ray report by Dr. Halbert: No acute infiltrates are seen. Impression: No active disease.

September 26, 2000 – ABG study by Dr. Musgrave (see chart above).

September 28, 2000 – X-ray report by Dr. Poulos: Comparison to the 9/25/00 study reveals no gross interval change. There are again chronic interstitial changes noted throughout both lung fields, but no pleural abnormalities are demonstrated. Impression: No active disease is noted.

September 30, 2000 – X-ray report by Dr. Poulos: Compared to the 9/29/00 study, the examination reveals no gross interval change. The lungs are clear of acute areas of infiltration or pleural disease. Chronic interstitial changes are noted throughout both lung fields. Impression: no active disease is noted.

October 5, 2000 – ABG study by Dr. Musgrave (see chart above).

October 21, 2000 – Discharge summary by Dr. Musgrave: Patient was admitted on September 23, 2000. He has a history of myeloma status post two bone marrow transplants. He presents with a fever, productive cough, increased congestion, increased shortness of breath, and chills. Physical examination revealed diminished breath sounds with some rhonchi in the posterior bases. He was admitted and placed on nebulized treatments and other medications. He had Staph growing in his sputum which proved negative, and he was placed on Levaquin for a community acquired pneumonia. Patient was discharged on 10/5/00. Diagnosis: exacerbation of chronic lung disease, silicosis, congestive heart failure, and myeloma.

October 25, 2000 – Admission report by Nurse Hurley: Patient is a non-smoker. Pulmonary examination revealed normal respiration. Breath sounds included rales and audible rhonchi upon expiration.

October 25, 2000 – X-ray report by Dr. Halbert: Lung fields are poorly expanded. The visible lung fields are clear.

October 26, 2000 – Examination report by Dr. Musgrave: Patient has history of multiple myeloma status post two bone marrow transplants, problems with silicosis, and frequent exacerbations of underlying lung disease. He does not smoke. Lung examination revealed diminished breath sounds and some crackles in his bases. Impression: chronic lung disease appears to be fairly stable but he did have an elevated white count.

December 4, 2000 – Discharge report by Dr. Musgrave: Patient was admitted on 10/26/2000 and discharged on 10/29/2000. He has a history of multiple myeloma, status post two bone marrow transplants; problems with silicosis, and has frequent exacerbations of underlying lung disease. Lungs revealed diminished breath sounds with some crackles in his bases.

December 4, 2000 – Emergency room report by Dr. Mills: Patient with a history of multiple myeloma without remission and COPD presented with shortness of breath and wheezing.

December 4, 2000 – X-ray report by Dr. Kendall: Comparison to 10/25/00. Lungs are clear. Impression: no evidence of acute cardiopulmonary disease.

December 27, 2000 – Sleep disorder consultation by Dr. Mettu: Patient has a history of multiple myeloma, silicosis, and chronic bronchitis, and has been taking bronchodilators. He also has shortness of breath and is on oxygen 24 hours per day. There is no change in his pattern of cough. Lungs are clear. Impression: COPD, silicosis, and multiple myeloma. (DX 6).

December 27, 2000 – Oncology progress note by Dr. Musgrave: Patient has a history of multiple myeloma and underlying silicosis. Lungs have diminished breath sounds. Impression: Myeloma, fluid retention that is aggravating his lung condition, and silicosis. (DX 9).

January 3, 2001 – X-ray report by Dr. West: There is no active consolidations or effusions and the heart is in the upper normal size range. Impression: no active pathology. While he does not drink or smoke, he previously chewed tobacco. Lung examination revealed wheezing in the anterior and posterior fields and retractions bilaterally in the posterior basis. Blood gases are unremarkable (see chart above). Assessment: acute exacerbation of COPD and multiple myeloma.

January 3, 2001 – ABG study by Dr. Wrede (see chart above).

January 4, 2001 – ABG study by Dr. Musgrave (see chart above).

January 4, 2001 – Examination report by Dr. Musgrave – Patient presented with multiple myeloma status post two bone marrow transplants and end stage silicosis. He is being treated with multiple medications including Flovent and is undergoing nebulizer treatments. Patient had an exacerbation of his underlying lung disease including shortness of breath, cough, sputum production, and pain in the right upper chest. Also, patient does not smoke or drink. Physical examination reveals markedly diminished breath sounds and crackles in the bases. Impression: silicosis, flare up of underlying lung disease, probably from upper respiratory infection, IgG myeloma, and high blood pressure.

January 3, 2001 – Admission assessment by Nurse Hurley. Patient presented with chest pains, cough, and fluid retention. Pulmonary examination revealed labored respiration, rhonchi, and wheezing. Patient is on O2.

January 3, 2001 – Echocardiography report by Dr. Puram: Right ventricle is normal and looks fair.

January 10, 2001 – Consultation summary report by Dr. Mettu: Patient's chief complains are shortness of breath, palpitations, and chest congestion. He also complains of cough and expectoration. He has a history of bone marrow transplants, multiple myeloma, silicosis, COPD, and hypertension. Patient does not drink or smoke. On examination the lungs revealed scattered rhonchi. Impression: acute bronchitis, COPD, and silicosis.

January 11, 2001 – ABG study by Dr. Musgrave (see chart above).

January 17, 2001 – ABG study by Dr. Musgrave (see chart above).

January 17, 2001 – X-ray report by Dr. Poulos: Comparison to the 1/3/01 study reveals no gross interval change. Lungs are slightly under expanded, chronic interstitial lung changes are noted throughout both lung fields, and there is no active infiltrates or pleural disease. Impression: no active disease is noted.

January 22, 2001 – ABG study by Dr. Musgrave (see chart above).

January 22, 2001 – X-ray report by Dr. West: There is some crowding of markings from submaximal inspiration without definite vascular congestion, edema, or effusion. Impression: no active pathology.

January 24, 2001 – ABG study by Dr. Musgrave (see chart above).

January 24, 2001 – X-ray report by Dr. Halbert: Heart size is normal and lung fields are poorly expanded. No acute infiltrates are seen and there is no active disease.

January 24, 2001 – Consultation report by Dr. De Joya: Patient presents with a history of IgG multiple myeloma, status post bone marrow transplant times two; silicosis by an open lung biopsy on three occasions, most recently in January 2000; and chronic lung disease. The patient does not drink or smoke and used to work in the rock mine as a blaster at a surface mine. Physical examination revealed symmetric air entry with poor inspiratory effort with clear breath sounds, no crackles, wheezes, or rhonchi. The most recent chest x-ray on January 22, 2001 shows no evidence of active pathology except for some maximal inspiration. Impression: IgG myeloma, silicosis, and exacerbation of chronic lung disease rule out Churg-Strauss syndrome.

February 6, 2001 – Discharge summary by Dr. Musgrave: Patient presented to the emergency room with exacerbation of his underlying lung disease, increased shortness of breath, and sputum production. Flutamide was not tolerated due to end stage silicosis and other conditions. Physical examination revealed diminished breath sounds and some crackles in the bases. Patient was admitted and during the course of treatment the Prednisone was reduced due to massive fluid retention which was felt to be cor pulmonale. Patient died on January 25, 2001. Discharge diagnosis included immunoglobulin G multiple myeloma, failed bone marrow transplant; end state silicosis; and respiratory insufficiency. The family did not want an autopsy.

Death Certificate

The death certificate, signed by Dr. Musgrave, lists that Miner's death was due to IgG myeloma and silicosis. (DX 5).

Narrative Medical Opinion

Dr. Musgrave, Miner's treating physician, submitted a letter on September 10, 2001. (DX 8). Dr. Musgrave stated that Miner had IgG multiple myeloma and underwent a bone marrow transplant that stabilized his myeloma. She also noted that Miner had underlying black lung disease. Dr. Musgrave further explained that Miner suffered from respiratory exacerbations just prior to his death and actually died in respiratory failure. Finally, while she ultimately

opined that Miner died as a result of his lung disease rather than the myeloma, I note that her opening sentence states that he died of IgG multiple myeloma.

Dr. Raphael Caffrey, a pathologist, submitted a medical report on March 22, 2002. (DX 19). Dr. Caffrey reviewed Miner's treatment a record including 17 chest x-rays, a death certificate, a September 10, 2001 letter from Dr. Musgrave, and a copy Miner's employment history form. Dr. Caffrey considered a 26-year coal mine employment history, and while he noted a history of chewing tobacco, also stated that Miner did not smoke. Based on this evidence, Dr. Caffrey opined that there was no objective data to support a diagnosis of silicosis. Citing medical literature, Dr. Caffrey stated, "If indeed Mr. Maynard had COPD, again I am not sure how this was diagnosed, and if the COPD was from emphysema, it therefore did not come from silicosis if indeed Mr. Maynard had silicosis." Dr. Caffrey also opined that due to Miner's departure from the mines in 1998, if he had actually suffered from industrial bronchitis, this condition would have resolved within six months of leaving the mines. Next, based on medical literature, Dr. Caffrey opined that if Miner suffered from COPD, then it was possible that this could have been from his use of chewing tobacco or possibly even second-hand smoke. Dr. Caffrey further theorized that Miner's possible COPD may have been associated with his possible sleep apnea.

Concerning cause of death, Dr. Caffrey disagreed with Dr. Musgrave's conclusion Miner's fluid retention was due to cor pulmonale because the January 4, 2001 echocardiogram stated that the right ventricle was normal. Dr. Caffrey also disagreed with Dr. Musgrave's opinion that Miner died as the result of his lung disease rather than the myeloma because the record does not establish the fact that Miner even had a lung disease. Dr. Caffrey concluded, however that Miner suffered from multiple myeloma with diffuse organ involvement, and this condition was the cause of death regardless of whether or not Miner suffered any other lung diseases such as COPD or silicosis. Finally, he noted that Miner's multiple myeloma was in no way related to coal dust inhalation.

Dr. Caffrey was deposed by the Employer on April 26, 2002, when he repeated the findings of his earlier written report. (DX 21). Dr. Caffrey also added that even assuming Miner suffered from clinical or legal pneumoconiosis, this condition would have in no way contributed or hastened Miner's death, and Miner would have died from the same cause and at the same time if he had never stepped foot or worked in the coal mine.

Dr. Gregory Fino, an internist, pulmonologist, and B-reader, submitted a medical report on April 1, 2002. (DX 20). Dr. Fino considered the following: employment history (26 years of coal mine employment, ending in 1998), smoking history, Miner's hospitalization and treatment records, the 2001 death certificate, and Dr. Musgrave's September 10, 2001 letter. Dr. Fino noted that the records revealed multiple diagnoses of silicosis, pneumoconiosis, COPD and asthma, but there was no objective evidence to support those diagnoses. Dr. Fino further explained:

> [T]here were no valid lung function studies to document an obstructive abnormality. There were on occasion some examinations that showed wheezing. The wheezing may very well be consistent with an underlying lung condition, and if that is the case, it would be consistent with asthma. Neither chronic obstructive pulmonary disease due to coal mine dust inhalation, pneumoconiosis, nor silicosis causes wheezing. During the final hospitalization, there were normal arterial blood gases although the amount of oxygen being given was not specified. There is mention of a lung biopsy from January of 2000 which was reported to show silicosis, but I have no proof of that in the records I have reviewed.

Dr. Fino concluded that based on the information available, he did not find any evidence that coal dust inhalation was a contributing factor in Miner's death. In addition, he stated that even assuming the existence of pneumoconiosis, he does not believe that pneumoconiosis cause, contributed to, or hastened Miner's death.

Dr. Fino was deposed by the Employer on May 2, 2002, when he repeated the findings of his earlier written report. (DX 22). Dr. Fino added that Miner's death was the result of multiple myeloma that remained uncontrollable despite two bone marrow transplants. Dr. Fino explained that myeloma results in abnormal production of blood cells, which leads to anemia, low immune protein levels, and an inability to fight infection. He also noted that during Miner's final hospitalization he had two different types of infections, and that the respiratory problems described in the records are typical of individuals who have multiple myeloma. Finally, Dr. Fino stated the medical literature provides absolutely no cause and effect relationship between any of the diseases listed under the diagnosis of CWP and multiple myeloma. As a result, he opined that the death certificate was incorrect when it stated that Miner's myeloma was due to or was a consequence of silicosis.

Smoking History

The March 22, 2000 PFT report notes that Miner smoked cigarettes for nine years at a rate of 1 ½ packs per day, or 13 pack-years, but that he quit around 1990. (DX 7). Dr. Cox's May 28, 1977 treatment note stated that Miner was advised to cut back on his smoking, but that he had not been able to. (DX 7). All other evidence in the record reports that Miner was a non-smoker. I note, however, that all of the physicians who listed Miner as a non-smoker submitted reports after the time that he purportedly quit smoking. Therefore, I find that Miner smoked for nine years at a rate on 1 ½ packs per day, or 13 pack-years, and that he quit in approximately 1990.

DISCUSSION AND APPLICABLE LAW

Mrs. Stanley filed her survivor's claim on March 4, 2002. (DX 3). Entitlement to benefits must be established under the regulatory criteria at Part 718. *See Neeley v. Director, OWCP*, 11 B.L.R. 1-85 (1988). The Act provides that benefits are provided to eligible survivors of a miner whose death was due to pneumoconiosis. § 718.205(a). In order to receive benefits, the claimant must prove that:

1). The miner had pneumoconiosis;

2). The miner's pneumoconiosis arose out of coal mine employment; and

3). The miner's death was due to pneumoconiosis.

§§ 718.205(a). Failure to establish any of these elements by a preponderance of the evidence precludes entitlement. *See Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989); *Trent v. Director, OWCP*, 11 B.L.R. 1-26, 1-27 (1987).

Pneumoconiosis

In establishing entitlement to benefits, Claimant must initially prove the existence of pneumoconiosis under § 718.202. Claimant has the burden of proving the existence of pneumoconiosis, as well as every element of entitlement, by a preponderance of the evidence. *See Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994). Pneumoconiosis is defined by the regulations:

> For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical" pneumoconiosis and statutory, or "legal" pneumoconiosis.
>
> (1) *Clinical Pneumoconiosis*. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
>
> (2) *Legal Pneumoconiosis*. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

Section 718.201(a).

Section 718.202(a) sets forth four methods for determining the existence of pneumoconiosis.

(1) Under § 718.202(a)(1), a finding that pneumoconiosis exists may be based upon x-ray evidence. The x-ray reports found in the treatment records are not in compliance with the quality standards of §718.102 and Appendix A to Part 718. As a result, they may not be considered

under § 718.202(a)(1). Therefore, I find that Claimant has failed to establish the existence of pneumoconiosis through x-ray evidence under subsection (a)(1).

(2) Under § 718.202(a)(2), a determination that pneumoconiosis is present may be based upon biopsy or autopsy evidence. Although Claimant designated Dr. Phillips January 2000 biopsy, and the treatment records reference multiple biopsies, there are no biopsy reports in record. In addition, Miner's family did not want an autopsy performed. Therefore, I find that the Claimant has failed to establish the existence of pneumoconiosis through biopsy or autopsy evidence under subsection (a)(2).

(3) Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found to be applicable. In this case, the presumption of § 718.304 does not apply because there is no evidence in the record of complicated pneumoconiosis. Section 718.305 is not applicable to claims filed after January 1, 1982. Finally, the presumption of § 718.306 is applicable only in a survivor's claim filed prior to June 30, 1982. Therefore, Claimant cannot establish pneumoconiosis under subsection (a)(3).

(4) The fourth and final way in which it is possible to establish the existence of pneumoconiosis under § 718.202 is set forth in subsection (a)(4) which provides in pertinent part:

> A determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

§ 718.202(a)(4).

This section requires a weighing of all relevant medical evidence to ascertain whether or not the claimant has established the presence of pneumoconiosis by a preponderance of the evidence. Any finding of pneumoconiosis under § 718.202(a)(4) must be based upon objective medical evidence and also be supported by a reasoned medical opinion. A reasoned opinion is one which contains underlying documentation adequate to support the physician's conclusions. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts, and other data on which he bases his diagnosis. *Oggero v. Director, OWCP*, 7 B.L.R. 1-860 (1985).

Silicosis is listed under §718.201 (a) as one of the diseases that qualifies as clinical pneumoconiosis. In December 1999, Dr. Irvin diagnosed silicosis by x-ray evidence. In addition, Dr. Musgrave diagnosed silicosis on 11 occasions and Dr. Mettu diagnosed the condition on four occasions. Dr. DeJoya also diagnosed silicosis based on the three lung biopsies. On the other hand, both Drs. Fino and Caffrey noted that there was no objective data in the record to support a finding of silicosis.

As noted above, Dr. Irvin's x-ray diagnosis of silicosis did not meet the quality standards of §718.102, and thus, could not be considered under §718.202(a)(1). In addition, none of the 19 equally situated subsequent x-ray interpretations mentioned the existence of silicosis. The most recent interpretation, January 24, 2001 by Dr. Halbert, stated that the film showed no acute infiltrate or active disease. Considering the progressive nature of pneumoconiosis, I find that these treatment x-rays do not support a finding of silicosis. In addition, a diagnosis of silicosis based on x-ray evidence alone is insufficient for the purpose of diagnosing pneumoconiosis under subsection (a)(4). *Cornett v. Benham Coal, Inc*., 227 F.3d 569 (6th Cir. 2000)(holding that merely restating an x-ray is not a reasoned medical judgment under § 718.202(a)(4))

Next, while Dr. Mettu and Musgrave diagnosed silicosis on a combined 15 occasions, as pointed out by Drs. Fino and Caffrey, neither of these physicians ever provided any objective support for their diagnoses. In addition, while the death certificate notes silicosis as a contributor to Miner's death, and Dr. Musgrave's September 2001 letter notes that Miner died from "black lung," I note that she still fails to provide any objective support for her opinion that Miner suffered from silicosis. Therefore, I find Drs. Mettu and Musgrave's opinions to be insufficiently documented, and thus, entitled to little weight.

Finally, if the biopsy reports Dr. DeJoya considered actually stated that Miner suffered from silicosis, then his diagnosis of the disease would be well-reasoned. However, since none of these reports are included in record, I find his report to be insufficiently documented, and therefore, accord it little weight.

Considering all of the evidence clinical pneumoconiosis under subsection (a)(4), I have found that the opinions by Drs. DeJoya, Mettu, and Musgrave are not well-documented due to their lack of any objective support in the record, and have thus, I accord them little weight. In addition, I have determined that Dr. Irvin's x-ray finding of silicosis is entitled to no weight under subsection (a)(4), and even if it could be considered in this analysis, it is outweighed by the 19 subsequent x-ray interpretations that made no mention of the condition. Finally, due to Dr. Irvin's report, I do not agree with the conclusions by Drs. Caffrey and Fino – there is no objective evidence in the record to support a finding of silicosis – but I do agree with their conclusions that the evidence of record does not support a finding of clinical pneumoconiosis. Therefore, I find that Claimant has failed to prove by a preponderance of the evidence under subsection (a)(4) that Miner suffered from clinical pneumoconiosis.

Turning to legal pneumoconiosis, the record is replete with treatment records supporting a finding of COPD in the form of chronic bronchitis. These diagnoses are supported by PFT and clinical examination evidence, and are thus well-reasoned and well-documented. However, I find little support for the contention that this condition was caused by coal dust exposure. In the December 27, 1999 report, Dr. Musgrave noted that Miner's lung disease was "thought" to be occupational. Since she provided no support for this conclusion, failed to even mention Miner's occupational history, inaccurately found Miner to be a non-smoker, and qualified her opinion by equivocally stating that she "thought" his lung disease was occupational. *Fuller v. Gibraltar Corp.*, 6 B.L.R. 1-292 (1984)(an unsupported medical conclusion is not a reasoned diagnosis); *Worhach v. Director, OWCP*, 17 B.L.R. 1-105 (1993)(per curiam)(it is proper for an ALJ to discredit a medical opinion based on an inaccurate length of coal mine employment); *Trumbo v.*

Reading Anthracite Co., 17 B.L.R. 1-85 (1993) (physician's opinion less probative where based on inaccurate smoking history); *Island Creek Coal Co. v. Holdman*, 202 F.3d 873 (6th Cir. 2000) (a physician, who concluded that simple pneumoconiosis "probably" would not disrupt a miner's pulmonary function, was equivocal and insufficient to "rule out" causal nexus as required by 20 C.F.R. §727.203(b)(3)). In addition, I note that none of Dr. Musgrave's 28 subsequent evidentiary entries identify any coal mine employment or smoking history at all. And with exception of the September 2001 letter in which he states, without support, that Miner suffered from underlying black lung disease; never does she provide any opinion that could be construed as a diagnosis of legal pneumoconiosis. Therefore, I find that while Dr. Musgrave's December 27, 1999 treatment report could be considered a diagnosis of legal pneumoconiosis, I find that this opinion is neither well-reasoned nor well-documented. Furthermore, I find that none of the subsequent evidence from Dr. Musgrave clearly diagnoses legal pneumoconiosis, and even if it did, I would not find such an opinion to be sufficiently documented.

Dr. Mettu's September 24, 2000 treatment report noted that Miner was a coal miner. Dr. DeJoya's January 24, 2001 report stated that Miner used to be a rock miner. In both of these reports the physicians opined that Miner suffered from COPD, but in nether report did the physician discuss length of coal mine employment or link Miner's coal mine employment to his COPD in any way. As a result, I find that neither Dr. Mettu nor Dr. DeJoya diagnosed legal pneumoconiosis.

Dr. Caffrey, a pathologist, submitted a medical evidence review in which he questioned the existence of COPD. He also stated that even if Miner suffered from COPD, it was in the form of emphysema and thus could not be the result of coal mine employment. In addition, he opined that any possible industrial bronchitis would have subsided within six months of leaving the mine, and that the COPD could have been the result of tobacco chewing or second-hand smoke. As noted above, I have found the treatment record replete with opinions based on objective evidence finding Miner to suffer from COPD from chronic bronchitis. I find that Dr. Caffrey's failure to explain why he discredited these multiple treating diagnoses undermines the credibility of his conclusions. *Duke v. Director, OWCP*, 6 B.L.R. 1-673 (1983)(a report is properly discredited where the physician does not explain how underlying documentation supports his or her diagnosis). Therefore, I find that Dr. Caffrey's opinion is not well-reasoned, and thus, entitled to little weight.

Dr. Fino, an internist, pulmonologist, and B-reader, noted that the record reveals multiple diagnoses of pneumoconiosis and COPD, but that there was no objective evidence to support those diagnoses. While the record supports Dr. Fino's conclusion with regard to legal pneumoconiosis, for the reasons I discredited Dr. Caffrey's report regarding the existence of COPD, I also discredit Dr. Fino's report. Specifically, while he found the sole PFT of record to be invalid due to a lack of three tracings, he still failed to account for the multiple clinical examinations that found Miner to suffer from COPD and chronic bronchitis. Therefore, despite Dr. Fino's advanced credentials, I accord his poorly reasoned report little weight.

It is clear from the treatment records that Miner suffered from COPD, but there are no well-reasoned and well-documented medical reports of record that provide a cause of this lung condition. In addition, while a couple of the treating physicians of record note that Mr. Maynard

previously worked in the coal mines, they never linked his COPD to coal dust exposure. And Dr. Musgrave, who "thought" Miner's lung disease was occupational in nature, never considered a smoking history or discussed Mr. Maynard's employment in the coal mines. As this is the only medical opinion of record to state, albeit vaguely, that Miner's COPD arose from his coal mine employment, and as I have found this opinion to be insufficiently reasoned and documented, I conclude that Claimant has failed to prove by a preponderance of the evidence, that Miner suffered from legal pneumoconiosis pursuant to subsection (a)(4).

Claimant has failed to establish the presence of either legal or clinical pneumoconiosis under subsections (a)(1)-(4). Therefore, after weighing all evidence of pneumoconiosis together under §718.202 (a), I find that Claimant has failed to establish the presence of pneumoconiosis by a preponderance of the evidence.

Entitlement

Debra Stanley has failed to prove, by a preponderance of the evidence, that James Maynard suffered from pneumoconiosis arising out of coal mine employment, or that his death was due to pneumoconiosis. Therefore, I find that Mrs. Stanley is not entitled to benefits under the Act.

Attorney's Fees

An award of attorney's fees is permitted only in cases in which the claimant is found to be entitled to benefits under the Act. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for the representation and services rendered in pursuit of the claim.

ORDER

IT IS ORDERED that the claim of Debra Stanley for benefits under the Act is hereby **DENIED.**

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THOMAS F. PHALEN, JR.
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed. At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.
If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).